

# Online Enrollment Guide

## Flexible Spending Account



**YOU MUST ENROLL EACH PLAN YEAR** online during Open Enrollment to continue participation in the FSA Program. Elections **DO NOT** rollover to the next plan year automatically. If you do not enroll during Open Enrollment, then you must wait until the next Open Enrollment Period or until a qualifying event occurs that would justify a mid-year election change.

### State of Delaware Flexible Spending Account Plan Online Enrollment and Elections

Please enter your Employee Identification Number:

### State of Delaware Flexible Spending Account Plan Online Enrollment and Elections

Please Enter the first 3 letters of your last name:

Please enter the initial of your first name:

Access the [ASIFlex Online Enrollment Site](#)

**Enter your Employee Identification Number**  
(Six-digit Employee ID **PLUS** the last four digits of the Social Security Number).

Click "Continue".

**Enter the first three letters of last name and then the initial of first name.**

Click "Continue".

*Employees may be prompted to enter full first name, last name or re-enter Employee Identification Number (Employee ID plus the last four digits of your social security number) for verification purposes.*

### **Why doesn't the system recognize my information?**

If system does not recognize your information, it may be due to:

- **Did not enter the Employee Identification Number correctly.** It is your 6 digit employee ID, plus the last four digits of your social security number (no dashes or spaces).
- **Did not enter name correctly.** The name provided to ASI is what is entered into PHRST. This will include initials, hyphenations, pre-fixes, suffixes, etc.

Make your selection from the list of available choices below:

- ☒ Flexible Spending Account Elections
- ☐ Mass Transit / Van Pool Elections
- ☐ Parking Elections
- ☐ Log out

Select "Flexible Spending Account Elections".

Click "Continue".

**Note:** *If you wish to make a change to your FSA Open Enrollment elections, you may login and enroll again anytime during Open Enrollment using this procedure. **The last enrollment submitted will be applied to your FSA participation.***

## Health Care Account (HCFSA)

If you wish to participate:

Select "Health Care Account".

Select either Pay Period or Annual to enter your deductions.  
You may then enter either the Pay Period Amount or Annual Amount.

Click "Calculate".

Click "Continue".

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If you **do not** wish to participate:

Select "Decline".

Click "Continue".

### Flexible Spending Account Elections

#### Health Care Account

You may choose to participate in a health FSA plan or you may decline to enroll in this portion of the program:

- ☒ Health Care Account  
☐ Decline, I realize I am forfeiting this cost-saving benefit.

#### HCSA Out-of-pocket medical, dental, vision, hearing expenses not paid by Insurance for you and your qualifying dependents

- Prescription Drug and Office Visit Co-pays
- Coinsurance, Deductibles
- X-ray, Lab, Hospital, Doctor expenses
- Mileage to/from health care providers
- Over-the-Counter health care products
- Over-the-Counter medicines/drugs
- Vision exams, eyeglasses, prescription sunglasses, over-the-counter reading glasses
- Contact lenses, cleaning solutions, vision correction surgery
- Dental exams, x-rays, fillings, crowns, bridges, dentures, denture adhesives, occlusal guards, orthodontia
- Hearing exams, hearing aids and batteries

Would you like to enter your elections by pay period or total for the plan year?

- ☐ Pay Period  
☒ Total for the plan year

Please enter the Annual Amount you would like to have deducted. Then click on the Calculate button to have the Pay Period Amount calculated based on the number of pay periods for the year.

Annual Amount	Pay Periods	Pay Period Amount	
\$2,750.00	/ 26	= \$105.77	<button>Calculate</button>

## Dependent Care Account (DCFSA)

If you wish to participate:

Select "Dependent Care Account".

Select either Pay Period or Annual to enter your deductions.  
You may then enter either the Pay Period Amount or Annual Amount.

Click "Calculate".

Click "Continue".

**You will be required to confirm the age and number of dependents covered under the Dependent Care FSA when enrolling.**

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If you **do not** wish to participate:

Select "Decline".

Click "Continue".

### Flexible Spending Account Elections

#### Dependent Care Account

You may choose to participate in the dependent care FSA plan or you may decline to enroll in this portion of the program:

**CAUTION! Do not put money into the Dependent Care Account for health care expenses. The Dependent Care Account is for work-related day care.**

- ☒ Dependent Care Account  
☐ Decline, I realize I am forfeiting this cost-saving benefit.

#### Dependent Care Account Child or adult daycare expenses while you work, look for work, or while your spouse is in full-time school Note: This is not health care

Minimum Election - \$50.00  
Maximum Election - \$5,000.00 (\$2,500.00 if married, filing separate tax returns)

- Work-related child or adult daycare expenses
- Preschool (pre-kindergarten)
- Nursery school
- Before school or after school care
- Day camps
- Adult care for qualifying dependent age 13 or older

Would you like to enter your elections by pay period or total for the plan year?

- ☐ Pay Period  
☒ Total for the plan year

Please enter the Annual Amount you would like to have deducted. Then click on the Calculate button to have the Pay Period Amount calculated based on the number of pay periods for the year.

Total for the Plan Year	Pay Periods	Pay Period Amount	
\$5,000.00	/ 26	= \$192.31	<button>Calculate</button>

**Reimbursement**

Note: If you change the information on this page, it will affect your direct deposit for ALL programs administered by ASIFlex.

☐ Use my banking info already on file

-- or --

☐ For rapid and secure reimbursement, to my bank account.

Routing Number:

Account Number:

Account Type:

-- or --

☐ Mail reimbursement check to my home. I understand that some banks may assess a fee to cash checks. I also understand that this reimbursement option is not recommended and that my employer and ASIFlex are not responsible for delayed or lost mail.

If you would like to be notified by text, email, or both, check the option(s) below and fill out the information requested.

☐ Text

Cell Phone Number:

Cell Phone Carrier:

☐ Email

Email Address:

## Reimbursement

Select preferred method of reimbursement.

Select your preferred notification method (*you may select both*).

Click "Continue".

## Debit Card

Choose **Yes** or **No** to indicate if you wish to receive a debit card. *If you are a current debit card holder, you **MUST** choose yes if you would like your card to be funded for the new plan year.*

Click "Continue".

**Debit Card**

Your employer offers a debit card which may be used for eligible health care expenses.



☒ Yes

☐ No

## Debit Card Application for Health Care FSA

Complete the Debit Card Application. Click "Continue".

**IMPORTANT:** The ASIFlex Debit Card provides a convenient method to pay for out-of-pocket health care expenses. The debit card is **NOT** paperless and **DOES NOT** eliminate paperwork.

## Review Before Sending

Review and confirm your elections. (Use "Go Back" to change your enrollment elections. *Do not use the web browser navigation to return to a page, otherwise **ALL** information will be **LOST**. The enrollment will **NOT** be completed.*)

Click "Confirm" to complete your enrollment.

## Your Elections Have Been Recorded

**Print or save this page for your records.**

**IMPORTANT:** It is highly recommended to print or save this screen for your records. A copy of the confirmation will be **REQUIRED** for any enrollment corrections.

Click "EXIT".

**Your Elections Have Been Recorded**

**Confirmation # J-415000-19-0925092126**

Category	Participate	Per Pay Period Contribution	Annual Contribution
Health Care Account	Yes	\$38.47	\$1,000.00
Dependent Care Account	Yes	\$192.31	\$5,000.00

**Reimbursements for Claims**

You have elected to receive reimbursements by **Direct Deposit**

You have selected texting for notification.

You have selected email for notification.

That's it! Your elections have been recorded. The confirmation number at the top is your indication that your enrollment elections have been received by ASIFlex. It is unnecessary to call to ask if we received it. **We only issue confirmation numbers like the one at the top of your screen for the enrollment elections that we successfully receive.**

**PLEASE PRINT THIS PAGE FOR YOUR RECORDS!**

For the protection of your privacy, we've made it impossible to retrieve your enrollment elections once you leave this screen. **Print this screen so that you have a record of your enrollment elections!**

Call ASIFlex at (800) 659-3035 if you need assistance with enrollment or have plan questions.